EXHIBIT 1: PROOF OF CLAIM NO. 1097

B10 (Official Form 10) (04/13) (Modified)

UNITED STATES BANKRUPTCY COURT EASTERN DISTRICT of MICHIGAN

CHAPTER 9 PROOF OF CLAIM

FILED
2014 FEB 19 A 10:34
U.S. BANKRUPTCY COURT
E.D. MICHIGAN-DETROIT

Name of Debtor: City of Detroit, Michigan | Case Number: 13-53846

NOTE: *Do not use this form to make a claim for an administrative expense that arises after the bankruptcy filing.*

Name of Creditor (the person or other entity to whom the debtor owes money or property):
Richard Hall

Name and address where notices should be sent:
Richard Hall
3752 Eastern Place
Detroit, MI 48208
Telephone number: 330-831-3346 email:

RECEIVED
FEB 20 2014
KURTZMANCARSONCONSULTANTS

COURT USE ONLY

☐ Check this box if this claim amends a previously filed claim.

Court Claim Number: _____ (If known)

Filed on: _____

Name and address where payment should be sent (if different from above):
7727 Bryden Street
Detroit, MI 48210
Telephone number: email:

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.

1. Amount of Claim as of Date Case Filed: $ 1,000,000.00

If all or part of the claim is secured, complete item 4.
If all or part of the claim is entitled to priority, complete item 5.
☐ Check this box if the claim includes interest or other charges in addition to the principal amount of the claim. Attach a statement that itemizes interest or charges.

2. Basis for Claim: (See instruction #2) False Arrest, excessive force, pursuant to 42 USC 1983 (for wrongful detention), assault & battery, false imprisonment under Michigan law

3. Last four digits of any number by which creditor identifies debtor:

3a. Debtor may have scheduled account as: (See instruction #3a)

4. Secured Claim (See instruction #4)
Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information.

Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any: $

Nature of property or right of setoff: ☐ Real Estate ☐ Motor Vehicle ☐ Other **Describe:**

Basis for perfection:

Value of Property: $

Amount of Secured Claim: $

Annual Interest Rate (when case was filed) ____% ☐ Fixed or ☐ Variable

Amount Unsecured: $

5. Amount of Claim Entitled to Priority as an Administrative Expense under 11 U.S.C. §§ 503(b)(9) and 507(a)(2). $

5b. Amount of Claim Otherwise Entitled to Priority. Specify Applicable Section of 11 U.S.C. § _____. $

6. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #6)

7. Documents: Attached are **redacted** copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, security agreements, or, in the case of a claim based on an open-end or revolving consumer credit agreement, a statement providing the information required by FRBP 3001(c)(3)(A). If the claim is secured, box 4 has been completed, and **redacted** copies of documents providing evidence of perfection of a security interest are attached. *(See instruction #7, and the definition of "redacted".)* DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.
If the documents are not available, please explain:

8. Signature: (See instruction # 8)
Check the appropriate box.

☒ I am the creditor. ☐ I am the creditor's authorized agent. ☐ I am the trustee, or the debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorsar, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: Richard Hall
Title:
Company:
Address and telephone number (if different from notice address above):

Richard Hall
(Signature) (Date)

3308313346 CookiacRamBS2@gmail.com
Telephone number: email:

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

13538461402180000000060

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date	Date of Accident	File Number
	Oct 29 2011	
Applicant's Name	**Home Phone Number**	**Business Phone Number**
Richard L. Hall		330 831 3346
Address	**Date of Birth**	**Social Security No.**
3752 Eastern Place Detroit MI 48208	11-11-75	385-66 7987
Date & Time of Accident (am/pm)	**Place of Incident (Exact Location)** on the front left yard of New Center Comm Health Dexter and Blvd	

Brief Description of Accident: Kicked in Ribs by Tall African American officer and Heavyset Caucasian officer laying his knees on back while assaulted Kneed in Nose by short Caucasian officer my

As a result of the incident were you injured? ☒Yes ☐No If yes, please complete the rest of this form.

Describe your injury Broken Nose / broken 8th and 9th Right Ribs

Were you treated in a Hospital? ☒Yes ☐ No If yes, please list Hospitals Name and Address.

Henry Ford Main Campus / E.R. 2799 W. Grand Blvd.

Did a Doctor treat you? ☒Yes ☐ No If yes, please list Doctor's Name and Address. Henry Ford

E.R. Doctors / Dr. Jones E.N.T. Unit Ears Nose Throat Surgery - NASAL

I, THE UNDERSIGNED, HEREBY AUTHORIZE ANY PHYSICIAN OR NURSE WHO ATTENDED THE ABOVE NAMED, OR ANY HOSPITAL AT WHICH ABOVE NAMED HAS BEEN CONFINED, TO FURNISH THE CITY OF DETROIT LAW DEPARTMENT, WITH ANY AND ALL INFORMATION WHICH MAY BE REQUESTED REGARDING PAST PHYSICAL CONDITION AND TREATMENT RENDERED AND TO ALLOW THEM OR ANY PHYSICIAN APPOINTED BY THEM TO EXAMINE AND COPY ANY AND ALL RECORDS WHICH YOU MAY HAVE REGARDING CONDITION OR TREATMENT, INCLUDING ALCOHOL AND DRUG PART 2, IF ANY; PSYCHOLOGICAL SERVICES AND SOCIAL SERVICES RECORDS INCLUDING COMMUNICATIONS MADE TO A SOCIAL WORKER OR PSYCHOLOGIST OR PSYCHIATRIST, IF ANY; RECORDS OF COMMUNICABLE DISEASES AND SERIOUS COMMUNICABLE DISEASES AND INFECTIONS, VENEREAL DISEASE (VD), TUBERCULOSIS (TB), HEPATITIS B, HUMAN IMMUNODEFICIENCY VIRUS (HIV), ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), AND AIDS RELATED COMPLEX (ARC), IF ANY. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW, PA 294 OF THE PUBLIC ACTS OF 1972.

I UNDERSTAND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE ISSUER OF THE MEDICAL RELEASE. YOUR PROTECTED HEALTH INFORMATION WILL BE DISCLOSED TO ANY AGENCY INVOLVED IN THE INVESTIGATION, EVALUATION AND RESOLUTION OF YOUR MATTER AS IT RELATES TO THE CITY OF DETROIT.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER SUBJECT TO PRIVACY PROTECTION PROVIDED BY LAW.

Richard Hall

NAME (Signature) DATE

SOCIAL SECURITY NUMBER DATE OF BIRTH

Subscribed and sworn to before me this

13 day of Feb, 2014

Anneliese Failla

Anneliese Failla, Notary Public an My Commission Expires: ____________

Macomb County, MI,

Acting in Wayne County

My Commission Expires 10/18/2014

MEDICARE REPORTING AFFIDAVIT AND INDEMNIFICATION OF THE CITY OF DETROIT BY THE CLAIMANT/PLAINTIFF

Richard Hall, **being first duly sworn, deposes and says that I have filed a claim and/or lawsuit against the City of Detroit:**

1. I certify under penalty of law that this Affidavit and all attachments were prepared with my knowledge and were reviewed by me. The information submitted is, to the best of my knowledge and belief, true, accurate and complete. I am aware that there are significant penalties for submitting false information, including the possibility of a fine and/or imprisonment for known violations. **I hereby state under oath and subject to any penalties for perjury that the information contained in this Affidavit is true, correct and accurate.**

2. I hereby understand that the City of Detroit will be relying upon this information in order to provide all of the required information to the United States Government, Department of Health and Human Services, Center for Medicare and Medicaid Services or their Medicare contractor in accordance with the Medicare, Medicaid and SCHIP Extension Act of 2007 and to be in compliance with the Medicare Secondary Payer Laws.

Circle One

3. I am currently receiving Medicare Benefits..... yes or (no)
4. I will be Sixty Five years old within three years..... yes or (no)
4a. I have applied for Social Security Disability Benefits..... yes or (no)
5. I have received a Social Security Disability Award Letter and attached a copy hereto.....yes or (no)
6. Attached is a copy of my Social Security Disability Application.....yes or (no)
7. Attached is a copy of my Social Security denial letter and my appeal of said denial..... yes or (no)

Circle One

8. I have End Stage Renal Disease.....yes or no

9. That my full name and all aliases are:

Richard Louis Hall

10. That my City of Detroit File Number is:

11. That my address is:

3752 Eastern Place Detroit MI 48208

12. That my Attorney's Name, Address and Contact Numbers are:

13. That my Date of Birth is:

11-11-1975

14. That my Social Security Number is:

385-66-7987

15. That my Medicare HIC Number, if applicable is:

N/A

16. That I am attaching copies of the following information:

a. Copy of the Judgment ..... yes or no

b. Medical Records ..... yes or no

c. Specific Description of my injuries Factual Nasal Fracture and 8th and 9th Right Ribs in An Assault + Battery by 3 D.P.D officers

Circle One

17. Has anyone ever prepared for you:

a. A Life Care Plan..... yes or (no)

b. Medicare Set Aside Cost Projections .....yes or (no)

c. Life expectancy projection .....yes or (no)

If yes to any questions above in #17, submit a copy to the City of Detroit.

18. What specific body parts were impacted by the Injury/illness:

Fractured Nasal

8 and 9 Right Ribs

19. That my Gender is: ✓ Male _____ Female

20. That the accident which gave rise to this Claim/Lawsuit occurred on:

Oct 29, 2011 (Date)

21. On _____ (Date), a Settlement or Judgement of my Claim/Lawsuit was agreed to/rendered for the total amount of _____ Dollars ($_____).

22. On the date of the accident/event, did any household family member own an automobile with valid No Fault Insurance coverage.....yes or (no)

I, Richard Hall, HAVE READ THE ABOVE MEDICARE REPORTING AFFIDAVIT AND STATE THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND CORRECT AND THAT IN THE EVENT THAT THE CITY OF DETROIT IS HELD LIABLE DUE TO ANY MISINFORMATION OR OMISSION OF INFORMATION BY AFFIANT IN THIS AFFIDAVIT, AFFIANT SHALL INDEMNIFY, HOLD HARMLESS AND REIMBURSE THE CITY OF DETROIT FOR ALL PAYMENTS, DAMAGES, MONIES, COSTS, ATTORNEY'S FEES, EXPENSES, MEDICARE LIENS, MEDICARE DEMANDS FOR REIMBURSEMENT, MEDICARE OFFSETS , MEDICARE FINES, MEDICARE PENALTIES AND ANY MEDICARE PAYMENTS INCURRED BY THE CITY OF DETROIT RESULTING FROM SAID OMISSION OR MISINFORMATION. FURTHER, I SHALL FULLY COOPERATE WITH THE CITY OF DETROIT IN ANY DISPUTE OR MATTERS RELATED TO THIS INCIDENT INVOLVING MEDICARE AND SHALL EXECUTE ALL DOCUMENTS REQUIRED OR REQUESTED BY THE CITY OF DETROIT, MEDICARE OR ITS AGENTS THAT MAY BE REQUIRED OR NECESSARY TO RESOLVE ANY SAID DISPUTE OR MATTER.

FURTHER AFFIANT SAITH NOT.

Richard Hall

SIGNATURE OF THE CLAIMANT/PLAINTIFF

This Medicare Reporting Affidavit and Indemnification was acknowledged, subscribed and sworn to before me this 13th day of Feb, 2014, by Richard Hall, who hereby declares under penalty of perjury under the laws of the State of Michigan that he or she is authorized in fact and law to execute this Medicare Reporting Affidavit and Indemnification.

Anneliese Failla

Anneliese Failla, Notary Public
Macomb County, MI,
Acting in Wayne County
My Commission Expires 10/18/2014

__, State of _____

NOTE: SHOULD THIS RELEASE BE SIGNED BY THE CLAIMANT/PLAINTIFF OUTSIDE OF THE STATE OF MICHIGAN THAT FACT MUST BE NOTED IN THE APPROPRIATE AREA ABOVE AND THE OUT OF STATE NOTARY MUST ATTACH A CERTIFICATE OF NOTARIAL AUTHORITY FROM THE STATE HE OR SHE IS AUTHORIZED TO ACT AS A NOTARY.

CITY OF DETROIT
LAW DEPARTMENT

COLEMAN A. YOUNG MUNICIPAL CENTER
2 WOODWARD AVENUE, SUITE 500
DETROIT, MICHIGAN 48226-3535
PHONE 313•224•4550
FAX 313•224•5505
WWW.DETROITMI.GOV

December 11, 2013

Richard Louis Hall
6433 Vinewood Street
Detroit, MI 48208

RE: Freedom of Information Act Request Dated May 15, 2013 Concerning Detroit Police Department (DPD) Records Pertaining to an Incident on October 29, 2011 Involving Richard Louis Hall

Dear Mr. Hall:

This letter serves as the City of Detroit's response to the above-referenced matter. Your request was received at the City of Detroit Law Department Governmental Affairs Section Freedom of Information Division on May 15, 2013. Thank you for your patience in this matter.

Your requests seek:

"4.	Type of record requested:	FOIA Internal Affairs Sgt. Roche at 313-596-2424 My Assault was under investigation by Sgt. Roche
5.	Name referred to in record:	Richard Louis Hall
6.	Type of incident, if any:	Assault & Battery on Oct. 29, 2011
7.	Date and time of incident, if any:	Oct. 29, 2011
8.	Detroit address or intersection of incident, if any: W. Grand Blvd & Dexter"	

As to any Internal Affairs investigation records, your request is denied pursuant to Section 13(1)(d), (m), and (s)(ix) of the Act, MCL 15.243(1)(d), (m) and (s)(ix), and Section 9(2) of the Michigan Bullard-Plawecki Employee Right-to-Know Act, MCL 423.509(2). Based on information provided by Detroit Police Department (DPD) personnel, it is our understanding that disciplinary actions against police officers are maintained separately by the DPD in accordance with MCL 423.509(2). Therefore, the release of such information would result in the violation of Michigan Bullard-Plawecki Employee Right-to-Know Act. As such, records of an internal investigation of police misconduct are exempt from disclosure. See also, Sutton v City of Oak Park, 251 Mich App 345; 650 NW2d 404 (2002).

Moreover, the release of the DPD Internal Affairs investigative records would create a chilling effect, and may result in intimidation or harassment of the complainant or the witnesses.

Therefore, the release of such record would do more harm than good for the public, as fewer individuals, including fellow police officers, would likely report police misconduct for fear of reprisal or retaliation. See, Newark Morning Ledger Co v Saginaw County Sheriff, 204 Mich App 215; 514 NW2d 213 (1994). Further, release of certain statements would violate Garrity rights of the police officers. Garrity v New Jersey, 385 US 493; 87 S Ct 616; 17 L Ed 562 (1967)

DPD did provide a copy of the Findings letter and to the extent this record corresponds to your request, your request is granted

.

The record from the Detroit Police Department consists of one (1) page. Enclosed please find one (1) copy of same. Because the enclosed record comprises fewer than ten (10) pages, no copying costs have been assessed.

Please be advised that, pursuant to Section 10 of the Michigan Freedom of Information Act, being MCL 15.240, a person receiving a written denial of a request may do one of the following:

1) Submit a written appeal to the head of the public body denying the request. Such appeal, if submitted, should specifically state the word "appeal" and identify the reason or reasons for reversal of the denial. MCL 15.240(1)(a); or

2) Commence an action in the circuit court to compel the disclosure of the public records within 180 days after the public body's denial of the request. MCL 15.240(1)(b). If a court finds that the information withheld by a public body is not exempt from disclosure, the requesting party may receive the requested record and, at the discretion of the court, reasonable attorney fees and /or costs. MCL 15.240(6) and (7).

Very truly yours,

Jack P. Dietrich
Assistant Corporation Counsel
Freedom of Information Section
(313) 237-5030

JD/

G:\DOCS\FOIA\dietjp\a37000\foia_grd\JPD4053.WPD

CITY OF DETROIT
DETROIT POLICE DEPARTMENT

1300 BEAUBIEN, SUITE 303
DETROIT, MICHIGAN 48226
PHONE 313•596•1800
WWW.DETROITMI.GOV

May 14, 2013

Mr. Richard Hall
6400 Beechwood
Detroit, Michigan 48210

Dear Mr. Richard Hall:

The Detroit Police Department and its members are firmly committed to providing professional service to the Detroit community and all citizens in general. To this end, incidents in which members of the community are injured are taken seriously and thoroughly investigated.

An investigation was conducted regarding an incident that occurred on October 29, 2011, in which you alleged that members of the Detroit Police Department used excessive force while you were in the area of Dexter and W. Grand Blvd. Please be advised that this investigation concluded with a finding of **"NOT SUSTAINED"**, as it relates to the allegations of excessive force.

If you have any questions, you may contact Lieutenant Anthony Topp, Monday through Friday, 8:00 A.M. to 4:00 P.M., at 313-596-2452.

BRIAN R. STAIR
Commander
Internal Controls

BRS/dsb

3752 Carter Pl.
D.O. ~~4480~~ 4/8208

Detroit Department Police

CITIZEN COMPLAINT REPORT

Report # 48535

Complainant:	*Date of Incident:*	*Date of Report:*
Richard Louis Hall	10/29/11	12/2/11

Complainant stated on 10/29/2011 at the above time and location. He was almost struck by a unmarked Detroit Police vehicle. Complainant fell from his bike and was approached by officers in vehicle. Complainant described officers as (1) white male, ball head, approx. age 30-40, 5'[7 or 9"], heavy build, (2) white male, age 45, 6'2", heavy build and (3) black male, age 30-40, 6'3", 240 lbs. All in plain clothes by officer with badge around neck. Complainant further stated that white officer placed his knee on complainant's back. The short white officer used his knee to hit Complainant's face and the black officer kicked Complainant on right side. A white marked Detroit police responded to location but was waved off by plain closed officers. The officers stated they were looking for guns. The short white officer pulled out a backup gun saying it belongs to Compl. The Complainant left the scene and was treated at the hospital for a broke nose and ribs. Notified Internal Affairs. Sgt. Roche advised make CCR and fax copy.

DETROIT POLICE DEPARTMENT

CITIZEN COMPLAINT REPORT

48535

DATE OF REPORT	TIME OF REPORT	OFFICER PREPARING REPORT	BADGE NUMBER	UNIT RECEIVING REPORT
12/2/11	1:30 PM	LT JAMIE MCCABE	[illegible]	CD

COMPLAINANT'S NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH	SEX
HALL	RICHARD	LOUIS	11-11-75	M

ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)	PHONE (RESIDENCE)	PHONE (BUSINESS)
6400 BEECHWOOD	DETROIT	MI	48210	313-624-5937	313-321-8648

AGENT REPRESENTING COMPLAINANT	RELATIONSHIP	PHONE

AREA(S) OF CONCERN			UNIT INVOLVED
1. FORCE	2.	3.	
1.	2.	3.	

DATE OF INCIDENT	TIME OF INCIDENT	LOCATION OF INCIDENT	NO. OF WITNESSES	NO. OF OFFICERS INVOLVED
10/29/11	1:30 AM	DEXTER / W. GRAND BLVD		3

INVOLVED OFFICERS: NAME & BADGE 1. 2. 3.

DETAILS OF INCIDENT:

COMPLAINANT STATED ON 10/29/2011 AT THE ABOVE TIME AND LOCATION HE WAS ALMOST STRUCK BY A UNMARKED DETROIT POLICE VEHICLE. COMPLAINANT FELL FROM HIS BIKE AND WAS APPROACHED BY OFFICERS IN VEHICLE. COMPLAINANT DESCRIBED OFFICERS AS ① W/M BALD HEAD APPROX AGE 30'S TO 40'S 5'7 HEAVY BUILD, ② W/M AGE 45 6'2 HEAVY BUILD AND ③ B/M AGE 30'S TO 40'S 6'3 [illegible] ALL IN PLAIN CLOTHES. B/M OFFICER WITH BADGE AROUND NECK. COMPL FURTHER STATED TALL WHITE OFFICER PLACED HIS KNEE ON COMPL'S BACK. THE SHORT WHITE OFFICER USED HIS KNEE TO HIT COMPL'S FACE AND THE BLACK OFFICER KICKED COMPL ON RIGHT SIDE. A WHITE MARKED DETROIT POLICE RESPONDED TO LOCATION BUT WAS WAVED OFF BY PLAIN CLOTHE OFFICERS. THE OFFICER STATED THEY WERE LOOKING FOR GUNS. THE SHORT WHITE OFFICER PULLED OUT A BACK UP GUN SAYING IT BELONGED TO COMPL. THE COMPL LEFT THE SCENE AND WAS TREATED AT THE HOSPITAL FOR A BROKE NOSE AND RIBS. NOTIFIED INTERNAL AFFAIRS SGT. ROCHE ADVISED MAKE CCR AND FAX COPY

IF RESOLVED, DESCRIBE RESOLUTION:

I HAVE RECEIVED A COPY OF THE ABOVE COMPLAINT AND ATTEST THAT THE INFORMATION THEREON IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS RELATED TO THIS INCIDENT.

( ) I ACCEPT RESOLUTION
( ) FURTHER INVESTIGATION REQUESTED

SIGNED X [illegible]
PERSON ENTERING COMPLAINT

COMPLAINT ENTERED ELSEWHERE?	LOCATION OF COMPLAINT ENTRY	MODE OF COMPLAINT ENTRY	DATE OF COMPLAINT ENTRY
( ) YES (✓) NO	CENTRAL DISTRICT	( ) PHONE ( ) LETTER (✓) WALKIN	12/2/2011

( ) THIS COMMAND HAS RESOLVED ( ) FORWARD TO UNIT:

SIGNED
OFFICER IN CHARGE

COPY 5
COMPLAINANT/AGENT

CITY OF DETROIT
POLICE DEPARTMENT

1300 BEAUBIEN, SUITE 303
DETROIT, MICHIGAN 48226
PHONE: 313•596•1800
WWW.DETROITMI.GOV

April 6, 2012

Mr. Richard Hall

Re: Force Investigation Case 12-009

Dear Mr. Hall

The Detroit Police Department is committed to providing professional service. I scheduled you for appointment on April 6, 2012, at 1:00 P.M. However, due to the current state of the city and the necessity to be available for any possible civil disturbance, the interview must be postponed. You a re tentatively scheduled for April 11, 2012, at 2:00PM. If this information changes you be notified.

Please call me at (313) 596-2424, Monday through Friday 8:00 a.m. to 4:00 p.m., if you have any questions or concerns.

Sincerely,

Tonyqua Roche

TONIQUA ROCHE
Sergeant, S-959
Force Investigation

WE FIGHT THE LAW, PLLC

ATTORNEYS AND COUNSELORS AT LAW

July 1, 2013

Richard Hall
6433 Vinewood St.
Detroit, MI 48210

RE: POLICE INCIDENT OF OCTOBER 28, 2011

Dear Mr. Hall:

As you know, the City of Detroit has failed to comply with our FOIA requests, causing our investigation to enter into a lengthy standstill. Because we have been unable to make progress in this regard, and with the statute of limitations rapidly approaching, (**October 28, 2013** for state claims, **October 28, 2014** for federal) we believe it would be in your best interest to speak with another lawyer about the facts of your case.

Because of this, and other recent developments, we will no longer be able to represent you. I do apologize, and it is my sincerest regret that we were unable to help you find justice. I am truly sorry we were unable to help you more Mr. Hall.

Enclosed you will find our file regarding your potential case. If you have any questions or concerns, please feel free to contact our offices.

Sincerely,

WE FIGHT THE LAW, PLLC

NICHOLAS JOSEPH KEITH
EXECUTIVE ADMINISTRATIVE COORDINATOR

NJK
Enclosures

17600 Northland Park Court
Suite 210
Southfield, MI 48075

PHONE (248) 443-9030
FAX (248) 443-9031
EMAIL Email@wefightthelaw.com
WEB http://www.wefightthelaw.com

DETROIT POLICE DEPARTMENT

CITIZEN COMPLAINT REPORT

48535

DATE OF REPORT	TIME OF REPORT	OFFICER PREPARING REPORT	BADGE NUMBER	UNIT RECEIVING REPORT
12/2/11	1:30 PM	LT Jamie McCrae	[illegible]	[illegible]

COMPLAINANT'S NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH	SEX
Hall	Richard	Louis	11-11-75	M

ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)	PHONE (RESIDENCE)	PHONE (BUSINESS)
6400 Beechwood	Detroit	MI	48210	313-624-5937	313-221-8641

AGENT REPRESENTING COMPLAINANT	RELATIONSHIP	PHONE

AREA(S) OF CONCERN			UNIT INVOLVED
1. Force	2.	3.	
1.	2.	3.	

DATE OF INCIDENT	TIME OF INCIDENT	LOCATION OF INCIDENT	NO. OF WITNESSES	NO. OF OFFICERS INVOLVED
10/29/11	1:30 AM	Dexter / W. Grand Blvd		3

INVOLVED OFFICERS: NAME & BADGE 1. 2. 3.

DETAILS OF INCIDENT:

Complainant stated on 10/29/2011 at the above time [illegible]

he was almost struck by a unmarked Detroit Police vehicle

[illegible]

in vehicle (complainant described) officers as ① W/M bald head [illegible]

[illegible]

③ B/M age 30's to 40's 6'3 240 lbs all in plain clothes. [illegible] officer

[illegible]

knee on compl's back. The short white officer used his knee to hit

[illegible]

marked Detroit Police responded to location but was waved off by plain

[illegible]

white officer pulled out a back up gun saying it belonged to [illegible]. The

[illegible]

Notified Internal Affairs Sgt. Roche advised make CCR and fax copy

IF RESOLVED, DESCRIBE RESOLUTION:

I HAVE RECEIVED A COPY OF THE ABOVE COMPLAINT AND ATTEST THAT THE INFORMATION THEREON IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS RELATED TO THIS INCIDENT.

( ) I ACCEPT RESOLUTION
( ) FURTHER INVESTIGATION REQUESTED

SIGNED X [illegible]
PERSON ENTERING COMPLAINT

COMPLAINT ENTERED ELSEWHERE?	LOCATION OF COMPLAINT ENTRY	MODE OF COMPLAINT ENTRY	DATE OF COMPLAINT ENTRY
( ) YES (✓) NO	Central District	( ) PHONE ( ) LETTER (✓) WALKIN	12/2/2011

( ) THIS COMMAND HAS RESOLVED ( ) FORWARD TO UNIT:

SIGNED ______________________
OFFICER IN CHARGE

COPY 5

DETROIT DEPARTMENT POLICE

CITIZEN COMPLAINT REPORT

48535

DATE OF REPORT	TIME OF REPORT	OFFICER PREPARING REPORT	BADGE NUMBER	UNIT RECEIVING REPORT
11/2/11	1 [illegible] AM	LT JAMIE MEL [illegible]	[illegible]	[illegible]

COMPLAINANT'S NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH	SEX
HALL	RICHARD	LOUIS	11-11-75	M

ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)	PHONE (RESIDENCE)	PHONE (BUSINESS)
6400 BEECHWOOD	DETROIT	MI	48210	313-624-5987	313-221-5641

AGENT REPRESENTING COMPLAINANT	RELATIONSHIP	PHONE

AREA(S) OF CONCERN	UNIT INVOLVED
1. FALSE 2. 3.	
AREA(S) OF CONCERN	UNIT INVOLVED
1. 2. 3.	

DATE OF INCIDENT	TIME OF INCIDENT	LOCATION OF INCIDENT	NO. OF WITNESSES	NO. OF OFFICERS INVOLVED
10/29/11	1:30 AM	DEXTER [illegible] BLVD		3

INVOLVED OFFICERS: NAME & BADGE 1. 2. 3.

DETAILS OF INCIDENT:

COMPLAINANT STATED ON 10/29/2011 AT THE ABOVE TIME AND LOCATION HE WAS AIM IT STOPPED BY A UNMARKED DETROIT POLICE VEHICLE COMPLAINANT FELL FROM HIS BIKE AND WAS APPROACHED BY OFFICERS IN VEHICLE. COMPLAINANT DESCRIBED OFFICER #1 W/M BALD HEAD TYPICAL AGE 30's TO 40's 5'7 HEAVY BUILD, #2 W/M AGE 45 6'2 HEAVY BUILD ING #3 B/M AGE 30's TO 40's 6'3 [illegible] ALL IN PLAIN CLOTHES BUT OFFICER WITH BADGE AROUND NECK. COMP FURTHER STATED TALL WHITE OFFICER PLACED HIS KNEE ON COMPL BACK THE SHORT WHITE OFFICER USED HIS KNEE TO HIT COMPL'S FACE AND THE BLACK OFFICER KICKED COMPL ON RIGHT SIDE. A WHITE MARKED DETROIT POLICE RESPONDED TO LOCATION BUT WAS WAVED OFF BY PLAIN CLOTHES OFFICERS. THE OFFICER STATED THEY WERE LOOKING FOR GUNS. THE SHORT WHITE OFFICER PULLED OUT A BACK UP GUN SAYING IT BELONGED TO [illegible]. THE COMPL LEFT THE SCENE AND WAS TREATED AT THE HOSPITAL FOR A BROKE NOSE AND WAS NOTIFIED INTERNAL AFFAIRS. DET ROLHC ADVISED MAKE FOR AND FAX COPY

IF RESOLVED, DESCRIBE RESOLUTION:

I HAVE RECEIVED A COPY OF THE ABOVE COMPLAINT AND ATTEST THAT THE INFORMATION THEREON IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS RELATED TO THIS INCIDENT.

( ) I ACCEPT RESOLUTION
( ) FURTHER INVESTIGATION REQUESTED

SIGNED X _____
PERSON ENTERING COMPLAINT

COMPLAINT ENTERED ELSEWHERE?	LOCATION OF COMPLAINT ENTRY	MODE OF COMPLAINT ENTRY	DATE OF COMPLAINT ENTRY
( ) YES (✓) NO	CENTRAL DISTRICT	( ) PHONE ( ) LETTER (✓) WALKIN	11/2/2011

( ) THIS COMMAND HAS RESOLVED ( ) FORWARD TO UNIT: _____

SIGNED _____
OFFICER IN CHARGE

DPD 512

COPY 5
COMPLAINANT/AGENT

DETROIT POLICE DEPARTMENT

CITIZEN COMPLAINT REPORT

48535

DATE OF REPORT	TIME OF REPORT	OFFICER PREPARING REPORT	BADGE NUMBER	UNIT RECEIVING REPORT
12/2/11	1:30 PM	LT JAMIE McCRAE	L-277	CD

COMPLAINANT'S NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH	SEX
HALL	RICHARD	LOUIS	11-11-75	M

ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)	PHONE (RESIDENCE)	PHONE (BUSINESS)
6400 BEECHWOOD	DETROIT	MI	48210	313-624-5887	313-721-1648

AGENT REPRESENTING COMPLAINANT	RELATIONSHIP	PHONE

AREA(S) OF CONCERN			UNIT INVOLVED
1. FORCE	2.	3.	
1.	2.	3.	

DATE OF INCIDENT	TIME OF INCIDENT	LOCATION OF INCIDENT	NO. OF WITNESSES	NO. OF OFFICERS INVOLVED
10/29/11	1:30 AM	DEXTER & W. GRAND BLVD		3

INVOLVED OFFICERS: NAME & BADGE 1. 2. 3.

DETAILS OF INCIDENT:

COMPLAINANT STATED ON 10/29/2011 AT THE ABOVE TIME [illegible]
HE WAS ALMOST STRUCK BY A UNMARKED DETROIT POLICE VEHICLE
COMPLAINANT FELL OFF OF HIS BIKE [illegible] APPROACHED BY OFFICERS
IN VEHICLE. COMPLAINANT DESCRIBED OFFICERS AS ① W/M BALD HEAD APPROX
AGE 30'S [illegible] 5'11" HEAVY BUILD [illegible] 45 [illegible] HEAVY [illegible]
③ B/M AGE 30'S TO 40'S 6'3" 240 LBS ALL IN PLAIN CLOTHES. ONE OFFICER
WITH POLICE [illegible]. COMPLT. THEN STATED THE WHITE OFFICER [illegible] HIS
KNEE ON COMPL'S BACK. THE SHORT WHITE OFFICER USED HIS KNEE TO HIT
COMPL'S FACE [illegible] OFFICER [illegible]
MARKED DETROIT POLICE RESPONDED TO LOCATION BUT WAS WAVED OFF BY PLAIN
CLOTHES OFFICERS. THE [illegible] THEY WERE LOOKING FOR GUNS. THE SHORT
WHITE OFFICER PULLED OUT A BACK UP GUN SAYING IT BELONGED TO COMPL. THE
COMPL. LEFT THE SCENE [illegible] AT THE HOSPITAL [illegible]
NOTIFIED INTERNAL AFFAIRS SGT ROCHE ADVISED MAKE CCR AND FAX COPY

RESOLVED, DESCRIBE RESOLUTION:

I HAVE RECEIVED A COPY OF THE ABOVE COMPLAINT AND ATTEST THAT THE INFORMATION THEREON IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS RELATED TO THIS INCIDENT.

( ) I ACCEPT RESOLUTION
( ) FURTHER INVESTIGATION REQUESTED

SIGNED X [signature]
PERSON ENTERING COMPLAINT

COMPLAINT ENTERED ELSEWHERE?	LOCATION OF COMPLAINT ENTRY	MODE OF COMPLAINT ENTRY	DATE OF COMPLAINT ENTRY
( ) YES (✓) NO	CENTRAL DISTRICT	( ) PHONE ( ) LETTER (✓) WALKIN	12/2/2011

THIS COMMAND HAS RESOLVED ( ) FORWARD TO UNIT:

SIGNED
OFFICER IN CHARGE

12

PHYSICIAN DOCUMENTATION SHEET
Sun Nov 13 08:01:23 EST 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 35
Complaint: Assault
Arrival Time: 10/29/2011 03:44
Account #: 1302
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Nasal Fracture
Discharge Time: 10/29/2011 07:54
All Providers: MD Mayura Phadtare; MD EM Staff Stephanie Stokes-Buzzelli

HPI:

The patient is a 35-year-old male who presents with a chief complaint of assault. The history was provided by the patient. Patient reports with assauklted with fists to face, back of head and chest by individuals just prior to ED arrival. Reports pain at back of head and right side of chest wall. Denies LOC, nausea/vomiting, or shortness of breath. Patient with recent right shoulder dislocation with shoulder in sling however denies any pain or new injury to shoulder at this time. The initial case discussion and decision making with stokes-Buzzelli, Stephanie - Emergency Medicine.

11:04 10/29/2011 by Mayura Phadtare, MD

ROS:

Constitutional: Negative for fever and chills.

07:07 10/29/2011 by Mayura Phadtare, MD

PMH:

Reviewed by: physician
Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Travel History: no recent foreign travel
Medical History: none
Surgical History: none
Family History: unknown
Immunization status: tetanus less than 5 years
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

07:07 10/29/2011 by Mayura Phadtare, MD

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
None		

Home Medication Verification: Verified With No Changes
07:07 10/29/2011 by Mayura Phadtare, MD

Physical examination:

Vital Signs: vital signs per nurses
Constitutional: alert, awake, comfortable appearance
O/E - head - general examn.: no bony depressions or step offs of skull NOTE - small hematoma on posterior aspect of scalp on left

Eyes: conjunctivae and lid normal, EOMI
ENMT: mouth and pharynx normal, dried blood in nares
Neck: supple, non-tender
Cardiovascular: regular rate and rhythm, NL S1/S2
Respiratory: breath sounds equal bilaterally, no rales, rhonchi, or wheezes
Chest: focal tenderness
Gastrointestinal: abdomen soft, nontender
Musculoskeletal: no Musculoskeletal pain
Skin normal: capillary refill normal, skin color good
Neuro: A&Ox3
Extremity Exam: normal appearance, No pedal edema
NOTE - nasal septum appears displaces with mild overlying edema
07:07 10/29/2011 by Mayura Phadtare, MD

Medical Decision Making:

Differential Diagnosis: contusion, fracture
Diagnostic Evaluation: xrays
Impressions: Will get xray of chest and nose to evaluate for fracture. Will not get CT due to mechanism, no LOC and unremarkable neurological or bony findings.
Amount and complexity of data: discussion with family
07:07 10/29/2011 by Mayura Phadtare, MD

Reassessment:

Reassessment of symptoms: improved
Radiographs reviewed: see radiograph report
Observations: remains awake and alert.
Reassessment: Possible small nondisplaced nasal fx. Will d/c home.
08:07 10/29/2011 by Mayura Phadtare, MD

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
None				continue

07:07 10/29/2011 by Mayura Phadtare, MD

Patient disposition:

Primary Diagnosis: Nasal Fracture
Additional diagnoses: contusions
Patient disposition: Disch - Home
07:07 10/29/2011 by Mayura Phadtare, MD

Discharge:

Discharge Instructions:
cold therapy, nasal fracture

Append a Note to Discharge Instructions: Follow up with ENT for your nasal bone fx - call to make an appt.

Referral/Appointment			
Refer Patient To:	**Phone Number:**	**Follow-up in**	**Appointment Details:**
Ent-Main Campus/313-916-3272			

07:08 10/29/2011 by Mayura Phadtare, MD

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
Motrin 800 mg Tab	#30	1 po 3-4 times a day prn pain
VICOdin ES 7.5 mg-750 mg Tab	#10	1 PO q4hrs prn pain

07:51 10/29/2011 by Mayura Phadtare, MD

Staff physician:

Teaching physician note: I personally saw and evaluated the patient. I was physically present for key portions of the services provided., I reviewed the resident's note and agree with the documented findings and plan of care without changes.
18:28 11/06/2011 by Stephanie Stokes-Buzzelli, MD EM Staff

Chart electronically signed by Responsible Physician
18:29 11/06/2011 by Stephanie Stokes-Buzzelli, MD EM Staff

PHYSICIAN DOCUMENTATION SHEET
Tue May 01 08:00:51 EDT 2012

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 36
Complaint: Rib pain
Arrival Time: 04/16/2012 20:30
Account #: 2107
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Rib fracture
Discharge Time: 04/16/2012 23:40
All Providers: MD Vinod Kumar; MD EM Staff Jumana Nagarwala

HPI:

The patient is a 36-year-old male who presents with a chief complaint of rib pain. The history was provided by the patient and CarePlus review. Patient says he was assaulted by the police in October 2011 and sustained broken ribs on the R chest and injuries to his R wrist. He has been having pain in the R chest and ribs ever since then. He was running away from dogs 4 days ago, jumped over a fence, and landed on the R chest. He denies SOB or pleuritic chest pain but is afraid that he reinjured his ribs. He has also been punched different objects with his R hand for the past few weeks and is concerned that he has reinjured the R wrist. Careplus review shows that in 2011 he had 2 stae flexor tendon rpair of R ring and middle finger, and clinic notes show that he had soft tissue swelling over the R wrist at that time. Patient asking for prescription for pain meds. The rib pain occurred several months ago. The mechanism of injury was a(n)assaulted. Localized symptoms include pain . The initial case discussion and decision making with nagarwala, Jumana - Emergency Medicine.

01:37 04/17/2012 by Vinod Kumar, MD

ROS:

Constitutional: Negative for fever.
Eyes: Negative for visual change.
ENMT: Negative for sore throat.
Cardiovascular: Negative for chest pain.
Respiratory: Negative for shortness of breath.
Gastrointestinal: Negative for nausea, vomiting, diarrhea and abdominal pain.
Genitourinary: Negative for dysuria.
Musculoskeletal: Positive for joint pain, joint swelling and arthralgias.
Skin: Negative for rash.
Neuro: Negative for headache and abnormal gait.
Psychiatric: Negative for behavior change.
Metabolic: Negative for excessive thirst.
Hematologic: Negative for anemia.
Allergic: Negative for rash.

01:36 04/17/2012 by Vinod Kumar, MD

PMH:

Reviewed by: physician

Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Travel History: no recent foreign travel
Medical History: none
Surgical History: hemorrhoidectomy
Family History: unknown
Immunization status: tetanus less than 5 years
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

01:37 04/17/2012 by Vinod Kumar, MD

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
Vicodin Oral		
ibuprofen Oral		

Home Medication Verification: Verified With No Changes
21:13 04/16/2012 by Lesley Fleming, Rn

Physical examination:
Vital Signs: vital signs per nurses
Constitutional: Oriented, Alert, in NAD
ENMT: ear, nose and throat exam normal, mouth and pharynx normal
Neck: supple, non-tender
Cardiovascular: regular rate and rhythm, NL S1/S2
Respiratory: breath sounds equal bilaterally, no rales, rhonchi, or wheezes
Chest: non-tender NOTE - patient not tender to firm palpation of the R chest with stethoscope, but flinches when chest is palpated. No crepitus, bony step off, or gross asymmetry of R chest compared to L chest

Gastrointestinal: abdomen soft, nontender, bowel Sounds present
Musculoskeletal: no Musculoskeletal pain
Skin normal: capillary refill normal
Neuro: A&Ox3, Cranial Nerves II-XII intact, gait normal, GCS=15
Extremity Exam: normal appearance NOTE - patient neurovascular intact in R hand. Soft tissue swelling over volar surface of R wrist. Mild tenderness over volar surface of R wrist. Pt unable to flex R 4th and 5th finger, says that this is an old injury.
01:41 04/17/2012 by Vinod Kumar, MD

Medical Decision Making:
Differential Diagnosis: contusion, fracture, muscular strain, pneumothorax
Impressions: Will obtain X-ray and rib imagining of R chest to rule out new fracture; low suspicion for acute fracture from exam. Similar low suspicion for R wrist acute process given exam but will check X-ray of R wrist. Pt given tylenol 3 for pain. He does not want to stay for evaluation, saying he will leave prior to X-rays if we give him "50 vicodin," but I told him that he should be properly

evaluated if he is concerned that he has new fractures. Pt agrees to stay.
01:43 04/17/2012 by Vinod Kumar, MD

Reassessment:
Reassessment: X-ray negative for acute process.
01:44 04/17/2012 by Vinod Kumar, MD

Reassessment:
Reassessment: X-ray negative for acute process.
01:44 04/17/2012 by Vinod Kumar, MD

Staff physician:
Teaching physician note: I personally saw and evaluated the patient. I was physically present for key portions of the services provided., I reviewed the resident's note and agree with the documented findings and plan of care without changes.
21:08 04/16/2012 by Jumana Nagarwala, MD EM Staff

Patient disposition:
Primary Diagnosis: rib fracture
Patient disposition: Disch - Home
23:25 04/16/2012 by Vinod Kumar, MD

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
Vicodin Oral				continue
ibuprofen Oral				continue

23:25 04/16/2012 by Vinod Kumar, MD

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
Vicodin 5 mg-500 mg Tab	5	1 po q4hr prn pain

23:34 04/16/2012 by Vinod Kumar, MD

Return to Work/School:
Sheet is for: Hall, Richard
Was in the ED from: 04/16/2012 20:30
Until: 04/16/2012 23:28
Return Disposition: May return to work without restrictions
Return Date: 04/17/2012
Restrictions/Instructions: No restrictions
Additional Note: Richard Hall was seen in the Henry Ford ED 4/16/12.
23:28 04/16/2012 by Vinod Kumar, MD

Discharge:

Append a Note to Discharge Instructions: You have an old rib fracture on the R side of your chest that is healing appropriately. Follow up with your PCP for further management of your pain. We cannot give large prescriptions for pain medicine like you are requesting.

Return to ED for breathing problems, chest pain, inability to walk, uncontrollable vomiting.
23:28 04/16/2012 by Vinod Kumar, MD

Documentation completed by Resident
01:44 04/17/2012 by Vinod Kumar, MD

PHYSICIAN DOCUMENTATION SHEET

Wed Oct 19 22:14:01 EDT 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 35
Complaint: Finger injury, Knee pain
Arrival Time: 10/19/2011 19:06
Account #: 1293
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Needle stick injury
Discharge Time: 10/19/2011 22:14
All Providers: PA Heather Shortridge; MD Michael Nauss

PMH:

Reviewed by: Physician Assistant
Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Medical History: none
Surgical History: none
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

21:42 10/19/2011 by Heather Shortridge, PA

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
None		

Home Medication Verification: Verified With No Changes
21:42 10/19/2011 by Heather Shortridge, PA

Staff physician:

Teaching physician note: I reviewed the PA's note and agree with the documented findings and plan of care without changes., I personally saw and evaluated the patient. I was physically present for key portions of the services provided.

Teaching physician addendum: pt states he was stuck by old needle. risk of transmission is likely very very low as the needle was sitting around for "3 months" per patient. Has discussion of testing for HIV and hepatitis (which he wanted). He stated he does have pmd and was told verbally to get repeat tests in 6 weeks. Pt was also told that sometimes these tests can be false positive.
21:09 10/19/2011 by Michael Nauss, MD

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
None				continue

21:43 10/19/2011 by Heather Shortridge, PA

Patient disposition:

Primary Diagnosis: needle stick injury
Additional diagnoses: knee pain
Patient disposition: Disch - Home
21:43 10/19/2011 by Heather Shortridge, PA

Discharge:

Discharge Instructions:
needle stick - without antivirals, r.i.c.e.

Drug Instructions:
pain nsaid motrin

Append a Note to Discharge Instructions: YOUR BLOOD TESTS WILL TAKE 2-3 DAYS. YOU WILL BE CONTACTED IF RESULTS ARE POSITIVE.

YOU CAN TAKE MOTRIN IF NEEDED FOR YOUR KNEE PAIN/HIP PAIN. FOLLOW INSTRUCTIONS FOR R.I.C.E. IF PAIN CONTINUES FOLLOW UP WITH YOUR DOCTOR IN 1 WEEK.
21:45 10/19/2011 by Heather Shortridge, PA

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
ibuprofen 800 mg Tab	30 tabs	1 pill po tid prn pain

22:09 10/19/2011 by Michael Nauss, MD

PHYSICIAN DOCUMENTATION SHEET
Tue Oct 25 13:18:17 EDT 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 35
Complaint: Finger injury, Knee pain
Arrival Time: 10/19/2011 19:06
Account #: 1293
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Needle stick injury
Discharge Time: 10/19/2011 22:14
All Providers: PA Heather Shortridge; MD Michael Nauss

HPI:

The patient is a 35-year-old male who presents with a chief complaint of finger injury. Pt c/o a needle stick that occured 2 weeks ago. Pt states that he was cleaning his house when he was stuck with an old insulin needle. The needle belonged to a now deceased family memeber. The family member died about 3 months ago of unknown causes. Pt states that after the needle stick he poured rubbing alcohol on the wound and then he poured bleach on the wound. Pt denies any erythema, edema, increased warmth, drainage from wound, and tenderness. Pt is also c/o R knee and R hip pain after playing basketball 3 days ago. Pt states that he came down wrong on his knee and has had pain since. Pt admits to pain with ambulation, moving around in bed, and just sitting. Pt denies any erythema of the skin or joints, edema, bruising, or deformity.

23:21 10/19/2011 by Heather Shortridge, PA

ROS:

Constitutional: Negative for fever, chills and sweats.
Eyes: Negative for eye pain, discharge and redness.
ENMT: Negative for ear pain, nasal congestion and rhinorrhea.
Cardiovascular: Negative for chest pain, peripheral edema and SOB on exertion .
Respiratory: Negative for cough, wheezing and shortness of breath.
Gastrointestinal: Negative for nausea, vomiting, diarrhea and abdominal pain.
Genitourinary: Negative for dysuria, Frequency and hematuria.
Musculoskeletal: Positive for joint pain, knee injury and trauma. Negative for joint swelling, back pain, neck pain, paresthesia, redness and reduced mobility.
Skin: Negative for rash, itching and swelling.
Neuro: Negative for headache, abnormal gait, dizziness and lightheadedness.
Allergic: Negative for rash, pruritus, dermatitis and hay fever.

23:22 10/19/2011 by Heather Shortridge, PA

PMH:

Reviewed by: Physician Assistant
Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Medical History: none
Surgical History: none

Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

21:42 10/19/2011 by Heather Shortridge, PA

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
None		

Home Medication Verification: Verified With No Changes
21:42 10/19/2011 by Heather Shortridge, PA

Physical examination:
Vital Signs: vital signs per nurses
Constitutional: Oriented, Alert, in NAD
Cardiovascular: regular rate and rhythm, NL S1/S2, no Murmurs, No JVD
Respiratory: breath sounds equal bilaterally, no rales, rhonchi, or wheezes
Gastrointestinal: abdomen soft, nontender, bowel Sounds present
Skin normal: capillary refill normal, skin color good

FInger examination							
Clinical findings	**Location**	**Palpation**	**Neuro exam**	**Vascular exam**	**Tendon exam**	**Nail exam**	**Other observations**
No abnormality							

hand examination						
Clinical findings	**Location**	**Palpation**	**Neuro exam**	**Vascular exam**	**Tendon exam**	**Other observations**
No abnormality						

Wrist examination						
Clinical findings	**Location**	**Palpation**	**Neuro exam**	**Vascular exam**	**Tendon exam**	**Other observations**
No abnormality						

forearm examination						
Clinical findings	**Location**	**Palpation**	**Neuro exam**	**Vascular exam**	**Tendon exam**	**Other observations**
No abnormality						

Lower leg examination					
Clinical findings	**Location**	**Palpation**	**Neuro exam**	**Vascular exam**	**Other observations**
No abnormality					

Knee examination					
Clinical findings	**Location**	**Palpation**	**Neuro exam**	**Vascular exam**	**Other observations**
No abnormality					

Upper leg/thigh examination					
Clinical findings	**Location**	**Palpation**	**Neuro exam**	**Vascular exam**	**Other observations**
No abnormality					

23:23 10/19/2011 by Heather Shortridge, PA

Medical Decision Making:

Differential Diagnosis: arthritis, bacteremia, cellulitis, contusion, dislocation, hepatitis B, hepatitis C, muscular strain

Diagnostic Evaluation: hepatitis screen, HIV - Human immunodeficiency virus test, xrays

Impressions: Pt has no signs of infection at the site of the needle stick. Pt is unsure of his last tetanus shot so he will be given a booster in the ER. Pt has no positive findings on his knee or hip exam but x rays will be done to r/o occult fracture.

ED monitoring: hemodynamic monitor (noninvasive), pulse oximetry monitor

Amount and complexity of data: discussion with patient, medical Records reviewed

23:26 10/19/2011 by Heather Shortridge, PA

Reassessment:

Radiographs reviewed: see radiograph report

Reassessment: Hepatitis screen and HIV labs were drawn and pt will be contacted if positive.

23:26 10/19/2011 by Heather Shortridge, PA

Staff physician:

Teaching physician note: I reviewed the PA's note and agree with the documented findings and plan of care without changes., I personally saw and evaluated the patient. I was physically present for key portions of the services provided.

Teaching physician addendum: pt states he was stuck by old needle. risk of transmission is likely

very very low as the needle was sitting around for "3 months" per patient. Has discussion of testing for HIV and hepatitis (which he wanted). He stated he does have pmd and was told verbally to get repeat tests in 6 weeks. Pt was also told that sometimes these tests can be false positive.
21:09 10/19/2011 by Michael Nauss, MD

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
None				continue

21:43 10/19/2011 by Heather Shortridge, PA

Patient disposition:
Primary Diagnosis: needle stick injury
Additional diagnoses: knee pain
Patient disposition: Disch - Home
21:43 10/19/2011 by Heather Shortridge, PA

Discharge:
Discharge Instructions:
needle stick - without antivirals, r.i.c.e.

Drug Instructions:
pain nsaid motrin

Append a Note to Discharge Instructions: YOUR BLOOD TESTS WILL TAKE 2-3 DAYS. YOU WILL BE CONTACTED IF RESULTS ARE POSITIVE.

YOU CAN TAKE MOTRIN IF NEEDED FOR YOUR KNEE PAIN/HIP PAIN. FOLLOW INSTRUCTIONS FOR R.I.C.E. IF PAIN CONTINUES FOLLOW UP WITH YOUR DOCTOR IN 1 WEEK.
21:45 10/19/2011 by Heather Shortridge, PA

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
ibuprofen 800 mg Tab	30 tabs	1 pill po tid prn pain

22:09 10/19/2011 by Michael Nauss, MD

Documentation completed by Mid-level Provider
23:45 10/19/2011 by Heather Shortridge, PA

Chart electronically signed by Responsible Physician
23:54 10/19/2011 by Michael Nauss, MD

PHYSICIAN DOCUMENTATION SHEET
Tue Sep 13 00:29:57 EDT 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 35
Complaint: Assault
Arrival Time: 08/30/2011 23:45
Account #: 1242
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Contusion - Facial
Discharge Time: 08/31/2011 02:46
All Providers: MD Jacqueline Pflaum; MD EM Staff Jumana Nagarwala

HPI:

The patient is a 35-year-old male who presents with a chief complaint of assault. The history was provided by the patient. Patient states that he was punched in the face by his girlfriend earlier this evening. He was trying to get his clothes from her apartmetn and she punched him in the nose, he states he had a little bit of bleeding but it really more concerned about teh swelling. He also states that she punched him in the left cheek last night where he still has pain. Denies blurred vision, LOC, headache, or nausea. The patient was struck with a(n) fist. The initial case discussion and decision making with nagarwala, Jumana - Emergency Medicine.

01:24 08/31/2011 by Jacqueline Pflaum, MD

ROS:

Constitutional: all Negative; Negative for fever and chills.
Eyes: all Negative
ENMT: all Negative
Cardiovascular: all Negative; Negative for chest pain.
Respiratory: all Negative; Negative for shortness of breath.
Gastrointestinal: Negative for nausea, vomiting, diarrhea and abdominal pain.
Genitourinary: Negative for Dribbling, Frequency, hematuria, hesitancy, testicular pain, testicular swelling, urethral discharge and urinary retention.
Musculoskeletal: all Negative
Skin: all Negative
Neuro: all Negative
Psychiatric: all Negative
Metabolic: all Negative
Hematologic: all Negative
Allergic: all Negative

01:24 08/31/2011 by Jacqueline Pflaum, MD

PMH:

Reviewed by: physician
Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Medical History: none

Surgical History: none
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

01:24 08/31/2011 by Jacqueline Pflaum, MD

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
None		

Home Medication Verification: Verified With No Changes
01:24 08/31/2011 by Jacqueline Pflaum, MD

Physical examination:
Vital Signs: vital signs per nurses
Constitutional: Oriented, Alert, in NAD
O/E - head - general examn.: no bony depressions or step offs of skull NOTE - Patient with some MILD swelling over the nasal bridge, no echymosis.

Eyes: EOMI, PERRL, fundi Clear w/o exudate or blood
ENMT: ear, nose and throat exam normal, mouth and pharynx normal
Neck: supple, no Thyromegaly, tenderness on bony C-spine palpation
Cardiovascular: regular rate and rhythm, NL S1/S2, no Murmurs, No JVD
Respiratory: breath sounds equal bilaterally, no rales, rhonchi, or wheezes
Chest: non-tender
Gastrointestinal: abdomen soft, nontender
Musculoskeletal: no Musculoskeletal pain
Skin normal: capillary refill normal
Neuro: A&Ox3, Cranial Nerves II-XII intact
Extremity Exam: normal appearance
01:25 08/31/2011 by Jacqueline Pflaum, MD

Medical Decision Making:
Differential Diagnosis: facial injury
Diagnostic Evaluation: CT C spine, CT maxillofacial
Initial ED therapy: analgesics
Amount and complexity of data: discussion with patient, medical Records reviewed, previous labs reviewed
01:25 08/31/2011 by Jacqueline Pflaum, MD

Reassessment:
Reassessment: Patient has no c/s fractures. No bony abnormalities. Will discharge home.
02:19 08/31/2011 by Jacqueline Pflaum, MD

Staff physician:

Teaching physician note: I personally saw and evaluated the patient. I was physically present for key portions of the services provided., I reviewed the resident's note and agree with the documented findings and plan of care without changes.

01:20 08/31/2011 by Jumana Nagarwala, MD EM Staff

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
None				continue

02:19 08/31/2011 by Jacqueline Pflaum, MD

Patient disposition:

Primary Diagnosis: contusion - Facial

Patient disposition: Disch - Home

02:19 08/31/2011 by Jacqueline Pflaum, MD

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
Tylenol-Codeine #3 300 mg-30 mg Tab	10	Take 1-2 pills by mouth every 8 hours as needed for pain

02:20 08/31/2011 by Jacqueline Pflaum, MD

Discharge:

Discharge Instructions:

cold therapy, contusion, facial contusion

Append a Note to Discharge Instructions: You were seen in the ED after being punched in the nose. You have no fractures on any of your xrays. Likely this is just a bad bruise. Keep the area iced. You WILL develop a bruise and possible some bruises under your eyes tomorrow, this is normal. You do not need to return to the ED for this.

02:24 08/31/2011 by Jacqueline Pflaum, MD

Documentation completed by Resident

13:06 09/06/2011 by Jacqueline Pflaum, MD

Chart electronically signed by Responsible Physician

00:29 09/13/2011 by Jumana Nagarwala, MD EM Staff

PHYSICIAN DOCUMENTATION SHEET
Thu Oct 27 10:01:08 EDT 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 35
Complaint: Shoulder pain

Account #: 1295
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Dislocation - Shoulder Anterior Closed

Arrival Time: 10/22/2011 17:57
Discharge Time: 10/22/2011 22:12
All Providers: PA Rya Lawrence; Ankit Nanavati; MD EM Staff Nikhil Goyal

HPI:

The patient is a 35-year-old male who presents with a chief complaint of shoulder pain. The history was provided by the patient and CarePlus review. Medical history is significant for no known medical problems. The shoulder pain occurred just prior to arrival. The description of the injury is a(n) deformity. The shoulder pain is located in the right shoulder. The mechanism of injury was a(n)slip and fall on a wet area. Localized symptoms include bony deformity and pain . There has been no associated focal neurological deficit or nausea and vomiting. The course is persistent. The patient was treated prior to arrival with nothing. The patient is right handed. The patient has had the following prior evaluations: none.

18:54 10/22/2011 by Rya Lawrence, PA

ROS:

Constitutional: Negative for fever and chills.
ENMT: Negative for nasal congestion, rhinorrhea and sore throat.
Cardiovascular: Negative for chest pain and palpitations.
Respiratory: Negative for cough and shortness of breath.
Gastrointestinal: Negative for nausea, vomiting, diarrhea, abdominal pain and constipation.
Genitourinary: Negative for dysuria.
Musculoskeletal: Positive for joint pain and joint swelling.
Skin: Negative for rash and itching.

18:55 10/22/2011 by Rya Lawrence, PA

PMH:

Reviewed by: Physician Assistant
Historian: the patient, CarePlus review, the patient's mother
Social History: non-smoker, alcohol use-none, drug use-none
Medical History: none
Surgical History: none
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

18:55 10/22/2011 by Rya Lawrence, PA

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
None		

Home Medication Verification: Verified With No Changes
18:53 10/22/2011 by Rya Lawrence, PA

Physical examination:
Vital Signs: vital signs per nurses
Constitutional: Oriented, Alert, in NAD

Upper arm examination					
Clinical findings	**Location**	**Palpation**	**Neuro exam**	**Vascular exam**	**Other observations**
No abnormality					

shoulder examination					
Clinical findings	**Location**	**Palpation**	**Neuro exam**	**Vascular exam**	**Other observations**
tenderness, dislocation of joint	right, anterior shoulder joint area		light touch sensation present	distal pulses normal, cap refill <2 seconds	

18:56 10/22/2011 by Rya Lawrence, PA

Medical Decision Making:
Differential Diagnosis: contusion, fracture, dislocation
Diagnostic Evaluation: xrays
Initial ED therapy: analgesics
Amount and complexity of data: discussion with patient, medical Records reviewed
18:57 10/22/2011 by Rya Lawrence, PA

Reassessment:
Reassessment: repeat X-ray showed proper reduction.
21:03 10/22/2011 by Ankit Nanavati

Staff physician:
Teaching physician note: I personally saw and evaluated the patient. I was physically present for key

portions of the services provided., I reviewed the resident's note and agree with the documented findings and plan of care without changes.
Procedures supervised include: Cardiac monitor/rhythm strip interpretation
20:00 10/22/2011 by Nikhil Goyal, MD EM Staff

Procedures:
Procedural sedation:
Indications : painful procedure
Consent:
written
Obtained from: self

ASA Score: 1. A normal healthy patient
Presedation checklist: awake and alert, patient on monitor, continuous pulse oximetry, supplemental oxygen provided, NPO status verified, suction available

Parenteral procedural sedation utilized			
Medication	**Dose**	**Units**	**Route**
midazolam	7.5		
fentanyl	75		

Complications: Negative for airway repositioning required, allergic reaction, hypotension, hypoxia, respiratory failure (bag-mask) and vomiting.
Postsedation assessment: alert, breathing easily, pain improved, successful procedure

Time Out Completed: yes
Confirmed with: Yeager RN, Gail
20:01 10/22/2011 by Nikhil Goyal, MD EM Staff

Procedures:
Ortho Procedure:
Procedure: dislocation reduction
Anesthesia: conscious sedation
Immobilization: sling
Reassessment: pain improved

Time Out Completed: yes
Confirmed with: Goyal, Nikhil

A resident performed the procedure(s). The supervising staff physician present for key parts of the procedure(s) was: Goyal, Nikhil - Emergency Medicine
22:00 10/22/2011 by Ankit Nanavati

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
None				continue

21:46 10/22/2011 by Rya Lawrence, PA

Patient disposition:
Primary Diagnosis: dislocation - Shoulder Anterior Closed
Patient disposition: Disch - Home
21:46 10/22/2011 by Rya Lawrence, PA

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
Motrin 800 mg Tab	#30	1 po 3-4 times a day
acetaminophen-codeine 300 mg-30 mg Tab	#25 (twenty five)	one-two q 4 hrs prn

21:50 10/22/2011 by Rya Lawrence, PA

Discharge:
Discharge Instructions:
cold therapy, dislocation, shoulder

Drug Instructions:
pain acetaminophen codeine, pain nsaid motrin

Append a Note to Discharge Instructions: use sling for 6 weeks no lifting on right shoulder follow up with athletic medicine in 1 week ice shoulder take motrin every 6-8 hours with food and take tylenol 3 as needed for break through pain.

Referral/Appointment			
Refer Patient To:	**Phone Number:**	**Follow-up in**	**Appointment Details:**
Athletic Medicine-Detroit 313 972 4200			

21:51 10/22/2011 by Rya Lawrence, PA

Documentation completed
22:00 10/22/2011 by Ankit Nanavati

Documentation completed by Mid-level Provider
23:10 10/22/2011 by Rya Lawrence, PA

Chart electronically signed by Responsible Physician
23:18 10/22/2011 by Nikhil Goyal, MD EM Staff

PHYSICIAN DOCUMENTATION SHEET
Mon Jan 16 07:39:48 EST 2012

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 36
Complaint: Chest pain
Arrival Time: 01/05/2012 22:20
Account #: 2005
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Rib fracture
Discharge Time: 01/06/2012 01:35
All Providers: Theresa Biesiada; MD EM Staff Raymond Fowkes

HPI:

The patient is a 36-year-old male who presents with a chief complaint of chest pain. The history was provided by the patient and CarePlus review. The onset of chest pain was 3 month(s) ago. Symptoms are characterized as moderate in intensity. The chest pain is located in the right chest. The chest pain has no radiation. The onset of chest pain was acute. It has been occurring for 3 month(s). The symptoms have been associated with nothing. The chest pain is/was precipitated by trauma. The symptoms have no aggravating factors. The symptoms have no relieving factors. The intensity is moderate. The course is worsening. The patient was treated prior to arrival with nothing. The response to treatment was no relief. The patient has had the following prior evaluations: chest X-ray and emergency Department visit. The Current Pain Severity is 5. The initial case discussion and decision making with fowkes, Raymond - Emergency Medicine.

02:24 01/06/2012 by Theresa Biesiada

ROS:

Constitutional: Negative for fever and chills.
Eyes: Negative for discharge.
ENMT: Negative for hearing loss and rhinorrhea.
Cardiovascular: Positive for chest pain. Negative for palpitations and SOB on exertion .
Respiratory: Negative for cough and shortness of breath.
Gastrointestinal: Negative for nausea, vomiting, diarrhea, abdominal pain and constipation.
Genitourinary: Negative for dysuria and urethral discharge.
Musculoskeletal: Negative for joint pain, back pain and neck pain.
Skin: Negative for rash.
Neuro: Negative for headache, dizziness and lightheadedness.
Psychiatric: Negative for anxiety.

00:05 01/06/2012 by Theresa Biesiada

PMH:

Reviewed by: physician
Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Travel History: no recent foreign travel
Medical History: none

Surgical History: hemorrhoidectomy
Family History: unknown
Immunization status: tetanus less than 5 years
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

00:05 01/06/2012 by Theresa Biesiada

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
Vicodin Oral		
ibuprofen Oral		

Home Medication Verification: Verified With No Changes
00:05 01/06/2012 by Theresa Biesiada

Physical examination:
Vital Signs: vital signs per nurses
Constitutional: Oriented, Alert, in NAD
Eyes: PERRL
ENMT: mouth and pharynx normal
Neck: supple, non-tender
Cardiovascular: regular rate and rhythm, NL S1/S2, no Murmurs, No JVD
Respiratory: breath sounds equal bilaterally, no rales, rhonchi, or wheezes
Chest: focal tenderness
Gastrointestinal: abdomen soft, nontender, bowel Sounds present, no masses palpated, no hepatosplenomegaly, no guarding or rebound
Musculoskeletal: no Musculoskeletal pain
Skin normal: capillary refill normal
Neuro: A&Ox3, Cranial Nerves II-XII intact, motor intact in all extremities, sensation normal
Extremity Exam: No pedal edema
00:05 01/06/2012 by Theresa Biesiada

Medical Decision Making:
Diagnostic Evaluation: CXR
Impressions: Chest pain - likely 2/2 known rib fx, will check CXR and rib series to r/o any displacement or change in the appearance of the fx as well as to r/o delayed pneumothx. Will treat pain.

Patinet also requesting treatment and testing for STDs, will provide these although patient cuirrently deneis any symptoms of STDs.
Initial ED therapy: antibiotics
Amount and complexity of data: discussion with patient, medical Records reviewed
01:18 01/06/2012 by Theresa Biesiada

Reassessment:

Reassessment: results reviewed with pt - GC/chlamydia tests sent and antibiotics given - patient discharged home.
01:18 01/06/2012 by Theresa Biesiada

EKG/RAD:
Chest X-Ray:
Normal

Other Radiology results	
Study	**Interpretation**
ribs	healing rib fx 8-9 on right side
shoulder L	no fx/dislocation

01:18 01/06/2012 by Theresa Biesiada

Reassessment:
Reassessment: results reviewed with pt - GC/chlamydia tests sent and antibiotics given - patient discharged home.
01:18 01/06/2012 by Theresa Biesiada

Staff physician:
Teaching physician note: I personally saw and evaluated the patient. I was physically present for key portions of the services provided., I reviewed the resident's note and agree with the documented findings and plan of care without changes.
Procedures performed: ECG interpretation (single)
01:58 01/06/2012 by Raymond Fowkes, MD EM Staff

Patient disposition:
Primary Diagnosis: rib fracture
Additional diagnoses: shoulder pain
Patient disposition: Disch - Home
00:52 01/06/2012 by Theresa Biesiada

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
Vicodin Oral				continue
ibuprofen Oral				continue

00:52 01/06/2012 by Theresa Biesiada

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**

Prescription		
Medication	**Dispense**	**Sig Line**
Vicodin ES 7.5 mg-750 mg Tab	#15 (fifteen)	1 po Q8hours PRN pain
ibuprofen 600 mg Tab	#60	1 po Q6hours PRN pain, take with food

00:53 01/06/2012 by Theresa Biesiada

Discharge:

Discharge Instructions:

Henry Ford Hospital 2799 W. Grand Blvd. Detroit, MI 48202 (313) 916-1545

Take-Home Instructions for the Patient

Patients Name: Hall, Richard L Date of Service: 01/05/2012 Medical Record Number: 33680716 Medical Provider: MD EM Staff Raymond Fowkes Primary Medical Provider: Theresa Biesiada Primary Diagnosis: Rib fracture Additional Diagnoses: Shoulder pain

PLEASE NOTE: The examination and treatment that you have received in the Emergency Department have been rendered on an emergency basis only and are not intended to be a substitute for or an effort to provide complete medical service. A follow-up doctor or facility is named below. It is important that you be checked again as recommended below and report any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. In addition, if an X-Ray has been taken here, it has been read on a preliminary basis only, and a final review will be made by the Radiologist.

Call to arrange an appointment to see the following physician for follow-up care. Referral:
****
Your x-rays show that your shoulder is normal and your rib fractures are healing appropriately.

Return to ER as needed. Take pain medications as prescribed. Use incentive spirometer at least 10 times per day.

Followup with your primary care doctor.

Your previous tests for STDs were negative. We have sent a new set of tests and you will be notified if any are positive.

Always have safe sex to avoid getting an STD.
****

ADDITIONAL FOLLOW-UP INSTRUCTIONS 1. If you have a physician at Henry Ford Hospital, call that physicians office directly for an appointment. If you dont know your doctors telephone number, call 1-800-HENRYFORD for assistance. 2. If you dont have a physician at Henry Ford Hospital, but would like one, contact your health insurer first to be sure they will cover your visit (telephone number is on your health card). If approved, call at 1-800-HENRYFORD for an appointment. If your health insurer will not authorize an appointment at Henry Ford Hospital ask for a physician within your health plan. 3. If you have a physician outside of Henry Ford Hospital, call your physicians office directly for an appointment. 4. If you have health insurance but no physician, call your insurance company for a referral to a physician in your health plan (telephone number is on your health card). If you are unable to get an appointment, ask which hospital

emergency rooms participate in your health plan so that you will not incur any out of pocket expense should you require further care. 5. If you are uninsured, and do not have a primary care physician, you can call to schedule a follow-up appointment at one of our affiliated health care clinic - CHASS Midtown. CHASS Midtown is located at 7436 Woodward, telephone number - 313-556-9907. Hours of operation: (Wed and Fri - 8:30am - 5:00pm) and (Mon, Tues and Thu - 12:00 noon - 8:00pm). 6. If you have Medicaid or a Medicaid HMO, please call 313-876-3810 for any follow up appointments you may need with the Henry Ford Health System.

When you call for an appointment, say that you were referred from this Emergency Department. Take all papers and prescriptions (be sure to get your prescriptions filled) given to you in the Emergency Department with you when you go to see the doctor. If you cannot see the above doctor and your condition worsens so that you require emergency treatment, come back to this department.

PLEASE TAKE THIS WITH YOU WHEN YOU SEE THE DOCTOR LISTED ABOVE

cold therapy

font table contains 2 fonts total Cold Therapy Your doctor advises cold therapy for your injury. This is the best initial treatment for sprains, muscle strains, and bruises (contusions). Cold therapy helps reduce pain, swelling, bleeding into the tissues, and muscle spasm from injuries. Pain relief from cold applications is due to a "counter-irritant" effect; at first the pain increases with the cold pack, then it becomes numb. The best way to apply cold treatments is with a plastic bag full of crushed ice, or a frozen gel pack. (Chemical cold packs are not recommended because they keep their cool for just a few minutes). Place the cold pack over the injury for 30 minutes; repeat the treatment every 2-3 hours for 2-3 days. Use a dry towel or washcloth between the cold pack and your skin to avoid injury to the skin. An elastic bandage can be applied over the ice pack to create compression; this is very effective in cooling injured tissues. Please do not leave the pack on for too long; it can cause frostbite. If you have circulation problems or a skin disease, you should not use ice packs because of the increased risk of causing frostbite injury.

rib fracture

font table contains 3 fonts total RIB FRACTURE: You have been diagnosed with a rib fracture ("broken rib").

Fracture means broken bone. Rib fractures are broken ribs. A chest wall contusion is a bruise to the muscles between the ribs. Both conditions are painful because every breath moves the injured area. Neither condition is dangerous by itself, but once in a while, complications like pneumonia or a collapsed lung occur. Rib fractures take 4 to 8 weeks to heal; your pain should gradually decrease over this time.

Do not bind or tape your ribs. Although binding or taping them may decrease the pain, it also increases the chance you will develop pneumonia.

Cough and breathe deeply at least 10 times an hour while you are awake, even if it is painful. Supporting the injured area with a pillow or your hand decreases the pain. Use pain medications as prescribed to control the pain so you can breathe normally and do your coughing and deep-breathing exercises. Doing these exercises can help prevent pneumonia.

YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

Shortness of breath, such as difficulty breathing or wheezing.
Coughing up green or yellow material.
Fever greater than 101 F (38.3 C) or persistent fever of any degree.
Severe chest pain or pain that becomes suddenly worse.
No improvement in the next few days.

safe sex

font table contains 4 fonts total SAFE SEX (EDU): Safe sex precautions are some simple recommendations to protect yourself and your sexual partner(s) from the risk of sexually transmitted diseases or "STDs."

Following these recommendations is, by no means, guaranteed protection from diseases that can be fatal such as HIV/AIDS.

There is no substitute for using your own good judgment before participating in sexual activity that might pose a risk of exposing you to a sexually transmitted disease.

The principal of safe sex is to avoid exposure or sharing of body fluids from another person. These fluids include semen from male ejaculation, female vaginal secretions, saliva and blood.

Using a condom during sexual intercourse can help minimize exposure to another's bodily fluids and is the most effective way to help prevent spread of sexually transmitted disease as well as avoid pregnancy. Condoms are not 100% effective as they may break during sex or have small holes in them. In general, though, they are very effective and should be used every time you have sex!

Make sure the condoms are not outdated by checking the expiration date on the packaging prior to use. Latex condoms are safest and most effective. Do not lubricate them with oil or Vaseline based products as they will weaken and break, making them ineffective. Only use a water based lubricant such as "K-Y Jelly" if necessary.

Avoid other forms of contact where bodily fluids may be shared such as mouth-to-vagina or mouth-to-penis. Anal or rectal intercourse may also result in exposure to bodily fluids. In this circumstance, condom use is highly recommended.

Often it is embarrassing to ask about such matters, but it is important to know as much as possible to protect yourself. Ask any questions to the medical staff prior to discharge. All such questions are appropriate and will be dealt with professionally and confidentially. Prescriptions Received: Vicodin ES 7.5 mg-750 mg Tab, ibuprofen 600 mg Tab Discharge Instructions Received: cold therapy, rib fracture, safe sex Drug Instructions Received:

_____ I hereby acknowledge receipt of the instructions indicated above. I understand that I have had emergency treatment and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as instructed above.

****

Your x-rays show that your shoulder is normal and your rib fractures are healing appropriately.

Return to ER as needed. Take pain medications as prescribed. Use incentive spirometer at least 10 times per day.

Followup with your primary care doctor.

Your previous tests for STDs were negative. We have sent a new set of tests and you will be notified if any are positive.

Always have safe sex to avoid getting an STD.
****

Date/Time: 01/16/12 07:39:48 Treating MD: MD EM Staff Raymond Fowkes

Patient Signature: _____ Suffix
Number: 2005 Medical Record Number: 33680716

I have explained the instructions and have given a copy to the patient.

Discharge Personnel Signature: _____ Date: _____

Append a Note to Discharge Instructions: Your x-rays show that your shoulder is normal and your rib fractures are healing appropriately.

Return to ER as needed. Take pain medications as prescribed. Use incentive spirometer at least 10 times per day.

Followup with your primary care doctor.

Your previous tests for STDs were negative. We have sent a new set of tests and you will be notified if any are positive.

Always have safe sex to avoid getting an STD.
00:55 01/06/2012 by Theresa Biesiada

Documentation completed by Resident
02:21 01/06/2012 by Theresa Biesiada

Chart electronically signed by Responsible Physician
04:52 01/06/2012 by Raymond Fowkes, MD EM Staff

Documentation completed by Resident
07:01 01/06/2012 by Theresa Biesiada

PHYSICIAN DOCUMENTATION SHEET
Tue Nov 29 09:33:11 EST 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 36
Complaint: Chest injury
Arrival Time: 11/19/2011 14:58
Account #: 1323
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Rib fracture
Discharge Time: 11/19/2011 20:22
All Providers: MD EM Staff Bradley Jaskulka; MD Adam Schlichting

HPI:

The patient is a 36-year-old male who presents with a chief complaint of chest injury. The history was provided by the patient and CarePlus review. Patient with multiple complaints. He had hemrrhoid surgery here 11/17 by Dr. Lee and was perscribed vicodin 750mg and motrin 800mg but lost the perscription. He also needs dressing for his hemorrhoids, has an old right chest injury and thinks he has cracked ribs so is requesting a chest x ray and has chronic shoulder dislocations. He has also been having unprotected sex with multiple partnets, so he wanted to be "checked". He denies discharge and has not had "carnal STDs" since the 1990s; he is checked frequently he states. No fevers, no chills, no abdomen pain. The initial case discussion and decision making with jaskulka, Bradley - Emergency Medicine.

17:04 11/19/2011 by Adam Schlichting, MD

ROS:

Constitutional: Negative for fever, weakness, chills and fatigue.
Eyes: Negative for eye pain, photophobia and redness.
ENMT: Negative for ear pain, hearing loss, epistaxis and nasal congestion.
Cardiovascular: Positive for chest pain. Negative for peripheral edema and SOB on exertion .
Respiratory: Negative for productive cough and shortness of breath.
Gastrointestinal: Negative for nausea, vomiting, diarrhea, abdominal pain and constipation. NOTE - hemrrhoid surgery pain, no discaheare or redness

Genitourinary: Negative for dysuria, hematuria and polyuria.
Musculoskeletal: Negative for joint pain, joint swelling, back pain and neck pain.
Skin: Negative for rash and dry skin.
Neuro: Positive for headache and neck stiffness. Negative for abnormal gait, dizziness, lightheadedness, memory impairment, syncope and vertigo.
Psychiatric: Negative for anxiety.
Metabolic: Negative for excessive thirst, cold intolerance and hair change.
Allergic: Negative for rash.

17:04 11/19/2011 by Adam Schlichting, MD

PMH:

Reviewed by: physician

Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Travel History: no recent foreign travel
Medical History: none
Surgical History: hemorrhoidectomy
Family History: unknown
Immunization status: tetanus less than 5 years
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

17:04 11/19/2011 by Adam Schlichting, MD

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
VICOdin Oral		
ibuprofen Oral		

Home Medication Verification: Verified With Changes
17:04 11/19/2011 by Adam Schlichting, MD

Physical examination:
Vital Signs: vital signs per nurses
Constitutional: Oriented, Alert, in NAD, alert, awake, comfortable appearance
O/E - head - general examn.: head atraumatic, normalcephalic, face atraumatic
Eyes: conjunctivae and lid normal, EOMI, PERRL, Sclera clear, no icterus
ENMT: ear, nose and throat exam normal
Neck: supple, non-tender, no Bruit, no meningeal signs
Cardiovascular: regular rate and rhythm, NL S1/S2, no Murmurs, No JVD
Respiratory: breath sounds equal bilaterally, no rales, rhonchi, or wheezes, normal respiratory effort/excursion
Chest: focal tenderness
Gastrointestinal: abdomen soft, nontender, bowel Sounds present
Musculoskeletal: no Musculoskeletal pain, Back nontender, Joints nontender
Skin normal: capillary refill normal, warm, skin color good, skin turgor normal
Neuro: A&Ox3, motor intact in all extremities, sensation normal , normal coordination, normal speech, GCS=15, no gross CN deficits
Extremity Exam: No pedal edema
17:04 11/19/2011 by Adam Schlichting, MD

Medical Decision Making:
Differential Diagnosis: chlamydial urethritis, GC - Gonococcus infection, noncompliance with medication regimen, rib pain
Diagnostic Evaluation: CXR, GC/ chlamydia
ED monitoring: hemodynamic monitor (noninvasive), pulse oximetry monitor
Amount and complexity of data: discussion with patient, medical Records reviewed
17:04 11/19/2011 by Adam Schlichting, MD

Documentation completed by Resident
19:53 11/19/2011 by Adam Schlichting, MD

Chart electronically signed by Responsible Physician
18:44 11/20/2011 by Bradley Jaskulka, MD EM Staff

being completely separated from the mucoperichondreal flap.

With the spur gone, the cartilage was seen to be deviated over to the left due to the prominent maxillary crest. The cartilage was separated from the maxillary crest by incising a small stip of cartilage from its inferior aspect.

A osteotome was used to take down the deviated portion of the nasal maxillary crest. Once taken down, the attention was directed towards the nasal bones. A small pocket in the piriform aperure skin was made. The lateral osteotomes were placed against the pyriform aperature just superior to the anterior insertion of the inferior turbinate. In a high low high fashion, the osteotome was advanced through the nasal bones, first on the left then the right. The nasal bones were mobilized and directed medially with good reduction.

The hemitransfixion and priform aperature incisions were then closed in an interupted fashion with 4-0 chromic suture. A quilting suture was placed across the nasal septum. There was only a a small rent at the site of the septal spur posteriorly, without any correspoding perforation on the opposite side of the septum.

The inferior turbinates were then outractured with good results.

The stomach was suctioned with a temporary orogastric tube.

Steri-Strips and an Aquaplast cast was then applied. Patient was then awakened and extubated without difficulty.

Attestation

I was present for the entire period between opening and closing of the procedure(s).

Signed by **LAMONT JONES MD** at **02/13/2012 11:15:55**.

PHYSICIAN DOCUMENTATION SHEET
Mon Apr 16 23:40:41 EDT 2012

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 36
Complaint:
Arrival Time: 04/16/2012 20:30
Account #: 2107
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Rib fracture
Discharge Time: 04/16/2012 23:40
All Providers: MD Vinod Kumar; MD EM Staff Jumana Nagarwala

PMH:

Reviewed by: nurse
Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Travel History: no recent foreign travel
Medical History: none
Surgical History: hemorrhoidectomy
Family History: unknown
Immunization status: tetanus less than 5 years
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

20:31 04/16/2012 by Adreanne Dudley, RN

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
Vicodin Oral		
ibuprofen Oral		

Home Medication Verification: Verified With No Changes
21:13 04/16/2012 by Lesley Fleming, Rn

Staff physician:

Teaching physician note: I personally saw and evaluated the patient. I was physically present for key portions of the services provided., I reviewed the resident's note and agree with the documented findings and plan of care without changes.
21:08 04/16/2012 by Jumana Nagarwala, MD EM Staff

Henry Ford Health System

Operative Note

Document State: **Final** (version 2)
Update Date/Time: **02/13/2012 11:15**

Patient Name: **HALL, RICHARD L.** MRN: **HF 33680716**
DOB/Age/Gender: **11/11/1975 36y Male**
Location: **HF,HF Medical Center-Detroit Campus Clinic ENT/Audiology (K8)**

Service Date/Time: **02/03/2012 11:16**
Provider: **WILLIAM YOUNG MD**
Responsible Staff: **LAMONT JONES MD**

Pre-Op Diagnoses:
1. nasal bone deformity s/p trauma
2. septal deviation
3. nasal obstruction
4. turbinate hypertrophy

Post-Op Diagnoses:

Anesthesia:	General
Senior Staff Physician:	JONES, LAMONT, MD
Resident:	YOUNG, WILLIAM, MD

Preop diagnosis:
1. nasal bone deformity s/p trauma
2. septal deviation
3. nasal obstruction
4. turbinate hypertrophy

Postop diagnosis:
1. nasal bone deformity s/p trauma
2. septal deviation
3. nasal obstruction
4. turbinate hypertrophy

procedure:
1. closed septorhinoplasty
2. bilateral inferior turbinate outfracture

Surgeon: Lamont Jones, MD
Resident Surgeon: Wm. Greg Young, MD

EBL 20ml

Findings: large left septal spur and deviation of the maxillary crest. C shaped deformity of the nasal bones with the right side concave and
the left convex.

Indications: Mr. Hall is a 36 year old male with a history of nasal trauma s/p assult with nasal bone fracture and septal deformity. He complained of nasal obstruction and a recommendation was made for closed rhinoplasty with osteotomies and septoplasty with inferior tubinate outfracture. Despite the risk of bleeding, infection, septal perforation, CSF leak, smell disturbance, continued nasal obstruction, need for further procedures, and the risk of anesthesia, the patient wished to proceed.

Description:
The patient was brought to the operating room by our anesthesia colleagues where she underwent general endotracheal anesthesia. Once an adequate plane of anesthesia was achieved, the patient was prepped and draped in the usual sterile fashion. The nose was packed with Afrin-soaked pledgets. The nose was also injected with total of 6 mL of 1% lidocaine, 1:100,000 epinephrine solution. After adequate time for vasoconstriction and anesthetic effect, examation of the anterior nose with the nasal speculum revealed a large left septal spur and maxillary crest prominence. A left sided hemitransfixion incision was made and a mucoperichondrial flap was elevated on the septum and a tunnel was also elevated along the nasal floor. The two tunnels were connected at the site of the left septal spur. The bony cartilagenous junction point was separated and the deviaed bone was taken down with the open Janson middleton forceps. The small piece of septal spur was also taken down after

Patient disposition:
Primary Diagnosis: rib fracture
Patient disposition: Disch - Home
23:25 04/16/2012 by Vinod Kumar, MD

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
Vicodin Oral				continue
ibuprofen Oral				continue

23:25 04/16/2012 by Vinod Kumar, MD

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
Vicodin 5 mg-500 mg Tab	5	1 po q4hr prn pain

23:34 04/16/2012 by Vinod Kumar, MD

Return to Work/School:
Sheet is for: Hall, Richard
Was in the ED from: 04/16/2012 20:30
Until: 04/16/2012 23:28
Return Disposition: May return to work without restrictions
Return Date: 04/17/2012
Restrictions/Instructions: No restrictions
Additional Note: Richard Hall was seen in the Henry Ford ED 4/16/12.
23:28 04/16/2012 by Vinod Kumar, MD

Discharge:
Append a Note to Discharge Instructions: You have an old rib fracture on the R side of your chest that is healing appropriately. Follow up with your PCP for further management of your pain. We cannot give large prescriptions for pain medicine like you are requesting.

Return to ED for breathing problems, chest pain, inability to walk, uncontrollable vomiting.
23:28 04/16/2012 by Vinod Kumar, MD

is required than a couple semesters of college in order to be a PA. He reports that he does not smoke, drink, or use illicit drugs; he has "5-year sober." He reports that previous 2 to 5 years marijuana was his drug of choice, but he had tried heroin crack and cocaine on and off for approximately 4.

MEDICATIONS
He reports that he is not taking any medications currently; however, he does have prescriptions for;
1. Vicodin.
2. Nasomist.
3. Bacitracin.

PAST MEDICAL HISTORY
Significant for right shoulder dislocation and nasal facture, status post repair on February 5th, 2012.

ALLERGIES
NKDA.

PHYSICAL EXAMINATION
VITAL SIGNS
His blood pressure was 123/61, pulse 89, weight 82.6 kg, height 6 feet.

HEART
Regular rate. No murmurs, rubs, or gallops.

LUNGS
CTA bilaterally. No wheezes, rales, or crackles.

HEAD AND NECK
The patient had slight tenderness to palpation along his cervical spinal musculature and the base of the head. There was no pain with extension and flexion and there was full range of motion.

NEUROLOGIC EXAMINATION
HIGHER CORTICAL FUNCTION - MENTAL STATUS
The patient is alert and oriented. Attention and concentration are good. Speech is fluent with no dysarthria and no aphasia. Recent and remote memory function is intact. Fund of knowledge is within average range. The patient completed a Montreal cognitive assessment and scored a 29/30 with 1 point lost in delayed recall where he couldn't remember the word "church;" otherwise, his language was intact and under fluency and naming of maximum words in 1 minute that begin with the letter "F," he had named 11 words in 15 seconds.

CRANIAL NERVES II THROUGH XII
II - Pupils are equal and reactive without afferent pupillary defect. Visual fields are intact to confrontation. Funduscopic examination shows sharp discs with normal vasculature. III, IV, and VI - No ptosis, extraocular movements are full with normal pursuit and saccades and no nystagmus. V - Light touch is intact in all three divisions. Motor V is intact. VII - No facial asymmetry or weakness. VIII - Acuity intact to finger rubbing. IX - Palate rises symmetrically in the midline. XI - Shoulder shrug is normal. XII - Tongue protrudes in the midline.

MOTOR EXAMINATION
Normal bulk and tone in all four extremities. Muscle strength

is 5/5 in all four extremities.

SENSORY EXAMINATION
Sensory examination is intact to light touch.

REFLEXES
Reflexes are 2/4 and symmetrical in all four extremities.
Plantar response is flexor bilaterally.

COORDINATION
Fine coordinated movements are performed well bilaterally.

GAIT AND STATION
Gait is normal. Romberg is negative.

LABS AND IMAGING
The patient had an MRI of his right shoulder due to dislocation on January 23rd, 2012, which was consistent with that as well as a fibrocartilaginous labral tear on the right. His rotator cuff was intact. CT C-spine and maxillofacial were done on August 31st, 2011, likely after an episode of being assaulted, which demonstrated mild degenerative changes at the C-spine at level C4 through C7.

ASSESSMENT AND PLAN
This is a 36-year-old male, who presents with bilateral temporoparietal headache that has been ongoing and daily for approximately a year as well as episodes of "losing time" in the setting of a normal neurological physical examination.

1. Headaches. These are likely new daily persistent headache, of migrainus or tension type. He does have features of migraine with the photophobia and phonophobia as well as nausea; however, the bilateral nature is more fitting with tension. It is recommended that the patient take daily amitriptyline, we will start at a low dose and increase in a month's time if he tolerates it. Side effects, risks/benefits were reviewed with the patient. Due to the report of neck pain and tenderness along the musculature, physical and occupational therapy will be recommended as this may assist in pain relief.

2. Memory loss. It is not suspected that the patient is suffering from epileptic events; however, in order to be sure, an EEG will be obtained. Due to his past traumatic events and change in mood and interest as well as reported sleep difficulties, it was recommended that he see and obtain therapy at behavioral health. The patient declined this and reported that he is not interested in counseling, psychiatric consultation, or behavioral therapy. It was explained to him that often times, depression or anxiety may manifest itself as difficulty with memory and sleep deficits; he was also told that headaches are common in such scenarios. The patient was encouraged that should he change his mind and like to obtain referral for this, to call our clinic and this can be arranged.

Follow up is recommended in 3 to 4 months, at which time we will review his EEG results and determine how the amitriptyline is working. It was recommended that he call in a month's time to discuss amitriptyline whether we should increase it. He was encouraged to call the clinic for any questions or concerns in the interim. The patient verbalized agreement and understanding of the included assessment and plan and follow up

recommendations. He requested that a copy of this office note be sent to sergeant Rosette in internal affairs at the police department. He did sign a waiver for release of medical information to sergeant, Rosette. This release form as well as the Montreal cognitive assessment will be scanned and uploaded into Care Plus. If patient's headaches do not respond to preventive medication imaging may be considered in the future.

CTECH
MT63/PMT/PNK/ACM
Job #710711

Attestation

I saw and evaluated the patient with KOMAL H ASHRAF MD and agree with KOMAL H ASHRAF MD's findings and plan unless otherwise noted below.

Signed by **IRAM F ZAMAN DO** at **02/08/2012 09:49:32**.

Henry Ford Health System **Office Note**

Document State: **Final** (version 3)
Update Date/Time: **02/08/2012 09:49**

Patient Name: **HALL, RICHARD L.** MRN: **HF 33680716**
DOB/Age/Gender: **11/11/1975 36y Male**
Location: **HF,HF Medical Center-Detroit Campus Clinic Neurology (K-11)**

Service Date/Time: **02/06/2012 00:00**
Provider: **KOMAL H ASHRAF MD**
Responsible Staff: **IRAM F ZAMAN DO**

CHIEF COMPLAINT
Headaches.

HPI
The patient is a 36-year-old right-handed male, who presents to the neurology clinic for the first time with complaints of bilateral temporoparietal "banging" headache. The patient reports that the headache began in April of 2011 and has been every day all day. He reports that the pain is 10/10 on a pain scale daily. He does not recall the last time that he was pain free. He does report photophobia and phonophobia as well as nausea. He denies any vomiting, numbness, tingling, weakness, or vision problems.

The patient reports that he also feels like his memory has decreased. He states that last year he had a few occasions of head injury and stress including a motor vehicle accident in which he was a passenger and suffered dizziness and minor head trauma at the time. In addition, he was assaulted twice per his report, once by a friend, and once by the police. He reports that since then, his memory has been 30% of what it used to be and he reports that "before my memory was very sharp." He reports that he has difficulty spelling simple words and has lost some moments in time and has difficulty with some recollection. He reports that there were approximately 10 to 20 spells within the last year that he has "lost memory." The patient does report that he has some pain and stiffness from the top of his neck radiating to the back of his head. He reports that this has become more significant from 1 of the assaults last year. During one of these episodes, he also reports bruising/injury to a few ribs as well as a concussion, and a broken nose, which he just got repaired yesterday. The patient reports that he has not tried anything for his headache. He has recently been given a prescription for Vicodin due to his nose surgery, but has not taken that to assess whether he would find relief for his headache. He also reports that he has had some difficulty sleeping. He has lost some interest in things that he used to do. He reports that he has loss of appetite and does not feel like eating very much and has difficulty with concentrating on tasks. He denies being suicidal or homicidal ideations. The patient reports that the headaches and the memory have become worse since the car accident and reported assaults.

REVIEW OF SYSTEMS
A 14-system review was completed with the following abnormalities: Migraine, memory loss, trouble thinking, and sleep problems. All other systems were reviewed and negative.

FAMILY MEDICAL HISTORY
Significant for his dad, who has migraine headache. All else is negative including MS, stroke, autoimmune problems.

SOCIAL HISTORY
The patient reports that he has completed his GED and a couple semesters of college. He is currently not working, however, does report that he had a job as a 'physician's assistant' in the past. This sounds questionable, however, because more schooling